McLaren–Central Michigan - MRI Safety Screening Form 2017

Name: ______________________________DOB: _____________Date: _________________
Exam Ordered: ____________________ Weight: _________ Height: ____________________

Some of the following items may be hazardous to your safety, and may interfere with your MRI examination. Please check the correct answer to each of the following questions.

Have you had any injury to the eye involving metal, such as metal shavings, carbon steel, grinding metal, shrapnel etc.? Yes ___ No ___ (If yes, please inform the MRI Technologist BEFORE completing this form.)

Stent (card is needed)	Yes___No___	Tattoos:	Yes___No___
Cardiac pacemaker or defibrillator	Yes___No___	Body Piercings	Yes___No ___
Internal Pacing wires	Yes___No___	Medication Patch	Yes___No ___
Aneurysm clips, staples, wires	Yes___No___	Hearing aid	Yes___No ___
Surgical clips in:		Dentures or partial plates	Yes___No___
head, neck, chest, abdomen	Yes___No___	Breathing disorder	Yes___No___
Insulin / infusion pump	Yes___No___	Motion disorder / anxiety	Yes___No___
Implanted drug infusion device	Yes___No___	Claustrophobia	Yes___No___
Eye or ear implant	Yes___No___	Seizures	Yes___No___
Bone growth / fusion stimulator	Yes___No___	Tether	Yes___No___
Shunt (spinal or head)	Yes___No___	Diabetic	Yes___No___
Bone treated with:		Penile implants	Yes___No___
rods, pins, plates, screws	Yes___No___	Any metal in body	Yes___No___
Metal fragments	Yes___No___	**Female patients only:**	
Metal wire / mesh	Yes___No___	Chance of Pregnancy	Yes___No___
Intravascular stent, filter, coil, wire	Yes___No___	Nursing mother	Yes___No___
Artificial limb / joint	Yes___No___	IUD or Diaphragm	Yes___No___

Please list all previous surgeries:

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Are you allergic to any medication? If so, please list: ______________________________________
Please list all medications; indicate which medications you will have taken the day of your scheduled MRI with *: ____

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Please explain symptoms / reason for exam: ____

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How long have you had the problem? ____
Have you had injury or surgery to this area? Yes ___ No___Explain____________________________

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Do you have any history of cancer? Yes ___ No ___If Yes, explain_______________________________

Have you had a previous MRI ____ CT ____ X-ray ___ of the area? If yes, where? ________________

Patient / Guardian Signature____

For MRI technologist only:

Technologist Signature____

Contrast injected______________________ Lot Number ________________ Exp. Date ________________GFR________

Notes____